## Genetics for Your Practice Registration Form

**REGISTRATION DEADLINE IS APRIL 4th, 2003**

Name: _____ Degrees: _____

Title: _____ Department/Branch: _____

Hospital/Organization: _____ Medical Specialty: _____

Mailing Address: _____ City: _____

State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

Please check which day of the conference you will be attending:

| | | Registration Fee |
|---|---|---|
| ☐ Nurses & Other Health Care Professionals: | Monday, April 14th, 2003 | **$50.00** |
| ☐ Physicians: | Tuesday, April 15th, 2003 | **$75.00** |

☐ *Please check here if you require special accommodations to fully participate in this meeting. We will contact you for more information.*

**Please make check or money order payable to the *Hawaii Department of Health*. Send completed registration form with your payment to:**

**Hawaii Dept of Health**
**CSHNB – Genetics Program**
**Attn: Allison Taylor**
**741 Sunset Avenue**
**Honolulu, HI 96816**